STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violation: 1 of 1 violation 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility neglected to follow its policy and procedure to notify the physician when R1 had a condition change and failed to assess a resident who became unresponsive. Facility neglected to have a policy when to monitor a resident's urinary output. The facility neglected to provide assessment and ongoing care and services while awaiting EMS. These failures contributed to a resident (R1) experiencing a delay of 6 hours and 15 minutes of notification of change to the physician and greater than 38 hours with no monitoring a residents urinary output. R1 was hospitalized and diagnosed with Septic Shock related to a kidney stone with urinary obstruction. R1 expired on November 7, 2017, two days after R1 was hospitalized on November 5, 2017. This applies to 1 of 3 residents (R1) reviewed for neglect in the sample of 3. The findings include: The facility's Abuse and Neglect Policy dated November 2017 states, "Neglect is the failure to provide necessary and adequate (medical,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires, but fails to provide that service.

The Physician Order Sheets dated through November 2017 shows R1 has a diagnosis including Diabetes, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Hemiplegia & Hemaparesis following a Cerebral Infarct affecting the left side, and Disorder of White blood cells.

The Minimum Data Set assessment dated August 24, 2017 shows R1's cognition is intact, requires two person assist for transfers, setup and supervision during meals, and is frequently incontinent.

The nurse's notes dated November 4, 2017 at 8:20 A.M., V9 (RN) documents received report from V15 to closely monitor resident for any health status changes. At 11:45 PM R1 in her bed, alert, awake and confused. R1 with yellow drool from her mouth. R1's vitals BP 98/72, P-95, R-22, Temp- 98.4 and O2 90% 3LNC. R1 is non-verbal able to answer questions by nodding her head yes and no. An hour later at (12:45A.M.) R1 has yellow drool from her mouth again. R1 stated, "please leave me alone." V9 closely monitored R1 through the remaining of the shift. R1 is confused, drooling, non-verbal, O2 sats 90% 3LNC. There is no documentation that staff notified R1's physician. At 6:00 A.M., R1 is alert, awake and confused. R1 has sunken eyes and pale colored skin. Called and notified V3 (Nurse Practitioner) received orders to start intravenous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

fluids (IV) and STAT (Immediate) lab orders. Updated day shift nurse about R1's condition and to closely monitor R1. (V9 notified V3 (N.P.) 6 hours and 15 minutes after R1's condition had changed.)

On December 18, 2017 at 7:40 AM, V4 (RN) said she was R1's nurse on November 4, 2017. V4 said she noticed R1 was more sleepy and lethargic. R1 was confused she couldn't remember my name. She had yellow drool on the side of her mouth and was not speaking. "I think because she was sleepy." V9 said she called V3 (Nurse Practitioner) on November 4, 2017 at 6:00 AM and notified V3 of R1's condition change (6 hours and 15 minutes later).

The facility's Urinary/Bladder report shows R1 did not show any documented urinary output for (38 hours and 5 minutes) from November 3, 2017 at 2:00 PM until she was transferred to the hospital on November 5, 2017 at 4:05 AM.

On December 19, 2017 at 2:15 PM, V14 (CNA) said she was R1's CNA on November 3, 2017 and November 4, 2017 for first and second shifts both days. R1 is alert and communicates her needs. R1 normally "never complained." R1 did complain of pain and "wanted to go to the bathroom." V14 said when a resident has urinary output they document in the medical record. V14 said she did not notice any changes in R1's urinary output or report to nursing any changes. (V14 documented one urinary output for R1 on November 3-4, 2017.

On December 19, 2017 at 2:00 PM, V11 (CNA) said she was R1's CNA on November 4, 2017 (third shift). V11 said R1 was a two person assist to the bathroom. V11 said she did not notice any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

changes in R1's urinary output or report any changes to nursing staff. V11 said she would notify nursing staff if a resident has a change in a resident's urinary output. V11 said when a resident has urinary output they document a resident's void in the medical record.

On December 19, 2017 at 1:35 PM, V15 (RN) said he was R1's nurse on November 3, 2017. V15 said he was not aware of any changes with R1's urinary output. R1 said staff should monitor a residents intake and urinary output.

On December 18, 2017 at 7:40 AM, V4 (RN) said "she did not know if R1 had any urine output" during her shift. V4 said she did not assess R1's urinary output. CNA's document when a resident voids or changes of their incontinent brief. V4 said staff are expected monitor a resident's output.

On December 19, 2017 at 9:09 AM, V9 (LPN) said she was R1's nurse on November 4, 2017. V9 said R1 was "declining at that time." V9 said she did not assess or monitor R1's urine output.

On December 20, 2017 at 10:30 AM, V2 (Director of Nursing) said intake and output are monitored if there is a physician's order to be monitored.

On December 20, 2017 at 9:30 AM, V3 (Nurse Practitioner) said she ordered IV fluids for R1 to keep her hydrated. V3 said she would not expect staff to monitor a residents output who is receiving IV fluids. "There is no way to monitor output unless a resident is on a urinary catheter." V3 said she would expect staff to notify her if a resident has no urinary output for greater than 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6 On December 28, 2017 at 9:00 AM, V3 said she did not make a visual assessment of R1 when she (R1) started to have changes in her condition. V3 did not assess R1 when her WBC was reported at a "crticial high" value of WBC-31. V3 said it was the weekend and she does not make rounds during the weekends. On December 28, 2017 at 11:30 AM, V19 (Medical Director) said it is the standard of care and protocol to monitor a residents intake and urinary output. The facility's Notification for Change of Condition Policy dated February 2017 states, The facility must immediately inform ... the resident's physician ... when there is ... "A significant change in the resident's physical, mental or psychosocial status (i.e. deterioration in health) ..." The facility did not have a Hydration Policy on when to monitor and assess a resident's urinary output. The nurse's notes on November 5, 2017 at 8:00 AM, V8 (LPN) documents received R1 awake at 11:00 PM. V8 in and out of R1's room medicating her with IV antibiotics (treatment for infection) and IV fluids. . R1 was alert and responsive to verbal and tactile (touch) stimulation. R1 laying with her head of the bed in a upright position. At 3:30 AM, R1 is unresponsive and unable to arouse. 911 called. The Nursing home to Hospital Transfer Form dated November 5, 2017 shows at 3:30 AM, R1's vitals BP-90/49, HR-56, R-18, O2 sats 92% 3LNC. No physical assessment of R1 is documented in her medical record describing her condition.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

The Emergency Medical Service (EMS) arrived at the facility at 3:38 AM. On arrival R1 was unresponsive. At 3:43 AM, R1's BP- 90/ (there was no diastolic reading) P-180 (weak), Resp- 24 and 76 % 2LNC.

The hospital records dated November 5, 2017 shows on arrival to the emergency department R1 was still unresponsive. Per EMS R1 was tachycardic irregular into the 180's. R1 was hypoxic 76% placed on a non-rebreather by EMS. "On arrival began to bag the patient intubated."

On December 28, 2017 at 10:15 AM, V8 (LPN) said she was R1's nurse on November 5, 2017 when R1 became unresponsive. V8 said she not familiar with R1's "baseline" health condition. V8 said when R1 became unresponsive she took R1's vital signs. R1's oxygen was dropping to 80% with oxygen on. V8 said someone placed a non-re breather mask on R1 to help her breathe. 911 came and took over.

The EMS report showed R1 was hypoxic on arrival to the facility. EMS placed a non-rebreather mask on R1. R1's medical records showed no documentation that the facility assessed or monitored the resident once she became unresponsive. The facility did not provide evidence of treatment and care for R1 until EMS arrived.

On December 28, 2017 at 11:30 AM, V19 (Medical Director) said it is the standard of care and protocol to monitor a residents intake and output who is receiving IV fluids. A WBC count of 31 "is pretty high" indicating an infection. That high of a count could indicate "Sepsis." If a resident is showing clinical symptoms (change in mental status, low blood pressure, and critically

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014344	A. BUILDING: _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

high WBC count) with elevated WBC count they should be sent to the hospital "immediately."

According to CDC (Centers for Disease and Control and Prevention) Sepsis is the body's extreme response to an infection. It is life-threatening, and without the timely treatment sepsis can rapidly cause tissue damage, organ failure and death.

On December 27, 2017 at 2:25 PM, V18 (Hospital Physician) said R1 was "very sick"when she came to the hospital on November 5, 2017. V18 said he was "surprised" they kept R1 at the facility on November 4, 2017 (the day she had a critical high WBC of 31) they send residents to the hospital for less acute reasons. V18 said anytime a resident is administered IV fluids it standard of care to monitor their intake and output. R1 "might have had a different outcome if things were identified earlier." V18 said R1 expired due to Septic Shock related to a kidney stone normally this is treatable.

On December 20, 2017 at 10:30 AM, V2 (DON) said when a resident has a condition change staff are expected to a perform an assessment of the resident and notify the physician.

The facility did not provide a policy with regarding what should be done when a resident has a change of condition.

(A)